| Aim | | Measure | | | | | | 2018/19 | | Target | | | | | 2019/20 YTD | | Change Ideas | | | | | Q1 Status Update July 2019 | Q2 Status Update October 2019 | Q3 Status Update January 2020 | Was this change idea implemented as intended? | Lessons Learned: What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
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| Issue | Quality dimension | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | Performance | Target | Target justification | Q4 2018/19 | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | Performance | External Collaborators | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Target for process measure | Comments | | | | | |
| M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on) | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Theme I: Timely and Efficient Transitions** | **Timely** | **The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (DD) for admission to an inpatient bed or operating room.** | **MANDATORY** | **Hours / All patients** | **CIHI NACRS / October 2018 – December 2018** | **632*** | **23.12 (Q3)** | **22 hours (Q3)** | **5% improvement over current performance** | **22.75 hrs** | **19.15 hrs** | **17.53 hrs** | **18.92 hrs** | **18.9 hrs (Q3)** | **COTA Humber River Hospital Toronto North Support Services Good Shepperd Non-Profit Housing formerly Bayview Community Services** | **1. Inpatient: Increase percentage of probable discharges 24-48 hours in advance of discharge recorded in Teletracker in order to help the Bed Control team plan.** | **1. Develop process to communicate in EMR probable discharges to Bed Control** | **% of probable discharge dates recorded in Cerner** | **5% improvement from current performance** | | The working group identified the idea to test in a PDSA is the concept of 'Discharge Train, which is the communication of discharge readiness to staff, family and caregivers through the visual display of traffic lights based on the patient's ability to meet certain milestones. The first working group meeting is to be scheduled in the summer 2019. | An audit of the daily goal rounds was conducted and included all the Medicine, Surgery and Menthal Health units. | All inpatient units update Teletracker during or after daily goal rounds. | No | **At this moment, the current EMR is not integrated with the Bed Control system. In 2020/21, we will explore opportunities for system improvement and continue to work towards standardizing MRP communication of EDD to clinical team.** |
| | | | | | | | | | | | | | | | | **2. Inpatient: Refresh and audit discharge conversations in daily goal rounds, including the opportunity to record estimated discharge dates (EDD) that are within 48hrs, rounding before 11am and discharges that may occur over the weekend.** | **2. Develop standard work for daily rounds to include probable discharge dates** | **% of patients discharged before 11am Audits** | **5% improvement from current performance 100% compliance** | | The working group identified an idea to test in a PDSA, which is to virtually connect with the physicians to engage them in daily goal rounds. One of the medicine units tested this PDSA to evaluate its effectiveness on increasing the number of estimated discharge dates recorded on the EMR | An audit of the daily goal rounds was conducted and included all the Medicine, Surgery and Menthal Health units. | Daily goal rounds are conducted regularly and provide the teams opportunity to discuss and record estimated discharge datas within 48hrs. 100% of daily goal rounds happen before 11 am. Currently data is not available to measure increased percentage of data entry. | Yes | **This change idea will continue in 2020/21 when we will scope out data integration opportunities to increase efficiencies associated with communication of EDD between systems across the hospital.** |
| | | | | | | | | | | | | | | | | **3. Emergency: Increasing awareness of community and outpatient resources that may help avoid ED visits and admissions.** | **3. Develop and provide education, information sessions and a list of available community and outpatient resources for ED care providers** | **3. The number of education sessions and number of care providers attended/ number of referrals from ED to community resources [baseline Q4 FY 18/19 quarter compared to Q1 FY 19/20)** | **# of care providers and # of referrals** | | One of the planned improvement initiatives to indirectly influence the Time to Inpatient Bed indicator is to increase awareness of community and outpatient resources that may help avoid ED visits and admissions. The information session at the Emergency Physician Meeting on June 3rd , was developed to provide education, information and a list of available community and outpatient resources for ED care providers in order to increase referrals to these resources. In the 6 months prior to this meeting there were 643 referrals from the ED to community resources. | The Nurse Practitioner from the Advanced RGP Assessment Unit and the GEM Nurse have provided an update to the ED physicians about the SGS clinics and services and the process for submitting referrals. This information was intended as an update for new ED physicians and a refresher for more senior staff. The next steps will be to monitor the number of referrals to SGS clinics and to standardize the referral process from ED physicians. This project was recommended to be closed. | NYGH Emergency made 643 referrals to outpatient and Home and Community Care in the 6 months leading up to this change initiative. After the presentation, the number of outpatient and community referrals made by NYGH Emergency physicians were 684 which is a 6.4% increase from baseline. | Yes | **This change idea provided information on outpatient and community resources for new physicians and a refresher for more senior staff in the Emergency Department. It succesfully increased the number of referrals made to these resources. Going forward, this initiative could be utilized on an annual basis as an education session of the current and new options for referrals.** |
| | | | | | | | | | | | | | | | | **4.Access to Resources and Community Support (ARCS) for Mental Health patients ARCS Quality Improvement Project: Review all return ED visits for patients on the ARCS program and based on findings, identify QI projects in order to increase the number of referrals to ARCS, which will include education with ED team and Crisis.** | **4. Information and education sessions for ED staff to promote and work in collaboration with ARCS resources for patients with mental health** | **4. change in number of referrals to ARCS program** | **5% increase** | | Arpil, May and June had 29, 26 and 27 referrals, respectively from NYGH to ARCS. There was 100% acceptance rate for the total 82 referrals sent to the program. | July, August and September had 24, 21 and 36 referrals, respectively from NYGH to ARCS. The acceptance rate of the total 81 referrals was 100%. | In November, ARCS received 21 referrals from NYGH and in October 26 referrals. The acceptance rate was 100% and 11.1% of patients accessed the ED for repeat visit in Q1 and 9.9% in Q2. The total number of referrals were 203 from April to November 2019 in comparison to 173 over the same time period in 2018. This represents 16.7% increase. | No | **This project required manual data collection and analysis which made it difficult to understand the reasons why patients were returning to the ED and to implement quality improvement initiatives. It's an excellent partnership between the organizations involved and we will apply this partnership model to other community initiatives in the future. In year 2020/21, we will focus on a new indicator for the QIP which will expand on this project.** |
| **Theme II: Service Excellence** | **Patient-centred** | Percentage of respondents who responded positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? | P | % / Survey respondents | CIHI CPES / Most recent consecutive 12-month period | 632* | 57.00% | 58% | | 55.40% | 45.50% | 56.10% | 60.70% | To be pulled March 30, 2020 53.3% (as of Feb.4,2020) n=522 | | 1. Medicine: Implement all electronic discharge documentation process with patient education on Medicine Units (continuation of initiative from 2018-2019). | 1. Continuation of Pilot Project | 1. % of discharge summaries generated by DynDoc | At least 95% of onboarded providers using DynDoc for progress notes. At least 50% of onboarded providers using DynDoc for discharge summaries. | | In Q1, the project included pilot implementation in the Emergency Department. Content was customized and tested in partnership with ED physicians. | In Q2, Geriatrics and Gastroenterology went live in July and August followed by General Internal Medicine in September. Each specialty was customized and tested in partnership with physicians. | Mental Health, Nephrology, Endocrine, and Respirology went live in Q3. Each specialty was customized and tested in partnership with physicians. The other medical subspecialties are on track for implementation in Q4. | Yes | **The project will continue in 2020 with the implementation of all-electronic discharge documentation process with patient education on the Surgery Units.** |
| | | | | | | | | | | | | | | | | 2. Corporate: Continuation of rollout of real-time and digitization of discharge support materials across organization | 2. Joint development with vendor | 2. Completion of digitization | Yes/No | | The rollout of the App continues over the Q1 and the summer to ED and 3W. | The rollout continued on 5NS and 6W. Real-time survey was trialed for 7 weeks using tablets and volunteers and it was determined the App is not suitable for this purpose due to the manual pull of the data which will require 1.0FTE. | After analyzing app utilization data for past quarters, the app was found to be underutilized on Medicine and Surgical units. As a result, the respective working groups decided to stop supporting updates and migrate all content to NYGH's mobile compatible website. Any new content from Medicine and Surgery will now be directly uploaded to NYGH's website. However, the app is being used in the Maternal Newborn department as it shows acceptable utilization for mobile apps i.e. within 15%. The Quality Improvement Office will monitor the utilization into Q4. | Yes | **We conducted a PDSA of real-time survey and based on the learnings and results we will implement patient experience data collection methods across the organization, share insights and co-design services with patient and families in 2020/21.** |
| | | | | | | | | | | | | | | | | 3. Inpatient: Implementation of discharge phone calls within Medicine Program. | 3. Develop in partnership with patients, providers, and staff post-discharge phone follow-up to evaluate patient's transition from hospital to community. | 3. Number of patients who received post-discharge follow-up phonecalls | 100% of discharges receiving calls on Medicine units | | The working group designed a document that includes scripting, post-discharge phone call questions as well as some answers to "frequently asked questions". Patient and Family Advisors were engaged in the design, review, revision of the questions and in the planning process to call patients 48 hours after discharge. | The working group piloted the discharge phone calls on the Medicine unit with the newly revised questions. We made minor adjustments in the survey and the process based on feedback and the working completed a standard work document for training and education. | Clinical Informatics updated the documentation of the survey in the EMR. Decision Support has been involved to monitor the documentation and patient feedback. The afternoon shift unit secretaries have been trained and are placing phone calls to discharge patients regularly. | Yes | **The discharge phone calls offer opportunities to obtain patient feedback regarding the discharge process and identify opportunities for improvement. Initially we faced challenges with resource limitations but we were able to identify dedicated employees on each unit and incorporated it into their daily duties. The project was successfully piloted and rolled out on the Medicine units. Patient feedback was instrumental in the development and design of the phone call questions and process.** |
| | | | | | | | | | | | | | | | | 4. Inpatient: Standardization of discharge planning (discharge checklist) across Medicine Program and Cancer unit. | 4. Development and implementation of discharge checklist | 4. Completion of process | Complete: Yes/No | | The discharge planning checklist is being designed by staff on Cancer and Medicine units. Clinical Informatics has been involved in order to re-design the current documentation template on the EMR and ensure consistency in the information documented. | Clinical Informatics is working on the design of the template with multi-disciplinary staff. | Clinical Informatics completed the SW, RT, Dietitians, Pharmacist, OT and PT documentation mapping to the template based on user feedback. Nursing, SLP and Unit Secretaries were engaged in the design revision of the discharge planning template at the end of Q3 and the final version was completed in early Q4 2019/20. The plan is to spread and scale the template to Surgery and the implementation across these programs will take place following the modifications. | Yes | **The discharge checklist improves communication between clinicians and the team during the discharge planning process and ensures standardized documentation in the EMR. Its success can be contributed to the multi-disciplinary staff who co-designed it with Clinical Informatics to be streamlined, comprehensive and easy to use. The project initially included Medicine and Cancer units only, but due to its efficient display of information in one view, we plan to spread and scale to Surgery and eventually to every unit across the hospital will be utilizing it during daily goal rounds and discharge planning meetings.** |
| **Theme III: Safe and Effective Care** | **Safe** | **Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.** | **MANDATORY** | **Count / Worker** | **Local data collection / January - December 2018** | **632*** | **307** | **280** | | **73** | **88** | **105** | **146** | **412** | | **1. Corporate: Education and Awareness Initiatives (continuation of initiative from 2018-2019). Prevention and Management of Aggressive Behaviours (PMAB) training. An organizational task force will support this initiative.** | **1. The education program will follow a Train the Trainer model and will have organization-wide roll out to frontline staff and physicians provided by our "NYGH PMAB trainers". Code White Response team, Emergency and Mental Health teams will be trained in specialized high risk curriculum.** | **Number of staff trained** | **500** | | Level II training session for nursing and allied health scheduled bi-weekly session are available on My Learning Edge from July to December. | Level II biweekly training sessions continue until end of December and they are filled to capacity. | In 2019 we initiated the launch of PMAB (Prevention and Management of Aggressive Behaviour) training for support, frontline and high risk staff at NYGH. Total staff trained on all levels since April 1, 2019 = 302. From April 2019 to present the breakdown of staff trained is as follows:<br>-Level 2 PMAB training (8 hours) – 158 (Level 2 training is for frontline nursing, allied health and physicians)<br>-High Risk WVP training (two days) – 144 (High risk training is for emergency department, security, mental health, SW and support staff for those areas).<br>For 2020 (Jan – March) there are 4 level 2 sessions and 2 level 1 sessions planned in addition to 14 high risk sessions.<br>Next fiscal year, we will be trialing a physician focused PMAB session. | Yes | **The training sessions were highly succesful and we will continue the organization-wide training roll out to frontline staff and physicians provided by our "NYGH PMAB trainers".** |

| AIM | | Measure | | | | | | | | | | | | | | | Change | | | | | | | |
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| Issue | Quality dimension | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | 2018/19 Performance | Target | Target justification | Q4 2018/19 | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | 2019/20 YTD Performance | External Collaborators | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Target for process measure | Comments | Q1 Status Update July 2019 | Q2 Status Update October 2019 | Q3 Status Update January 2020 | Was this change idea implemented as intended? | Lessons Learned: What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
| | | | | | | | | | | | | | | | | 2. Corporate: Increase flagging of potential patients with history of aggressive behaviours and risk stratification by severity(continuation of initiative from 2018-2019). An organizational task force will support this initiative. | 2. Implementation and rollout of changes to Care Plan documentation in Cerner across the organization. | Number of days lost to WPV | 6 | | The Bahavioural Assessment that will be in the chart will be combined with the Professional Practice lead responsive behaviours pathway. Policies and educational modules will be developed this summer for rollout slated for middle of September. Electronic assessment as well as visual triggers including armband and signage. There were 85 reported Workplace Violence incidents from April to June 2019. | The behavioral safety program launched in Sept 25th and it is built to their daily nursing assessment. If triggered armband, Cerner and room visual triggers will be in placed. In the SLIP system staff will track if safety alert was in place as a measure of compliance. High risk training also started by an external expert company and it is focusing on Security, Emerge, Code White team and SW team who are high risk areas. It includes team based interventions. | From September 25th to December 23rd, 2019 there were 160 patients identified with the potential to harm self or others. To support this initiative there are ongoing audits to ensure that safety alerts were in place to protect everyone.<br>For Q1, Q2 and Q3 there was one LTI claim related to WV with one lost day. Monthly reports of incidents of workplace violence are now shared with unit/program leadership across all sites (General, SHC, RCC). The monthly reports include the nubmer of incidents in the previous month, each year with retrospective totals from 2014, breakdown of types of incidents (physical vs verbal), patients with repeat repeat incidents and organizational wide monthly and annually. In addition, there is reporting to senior leadership and board level which includes the breakdown of incidents based on severity and not only incidents resulted in lost time but those resulted in a healthcare worker requiring First Aid or medical care. There were a total of 412 workplace violence incidents from January to December 2019. | Yes | The audits ensure that patients with the potential to harm have a safety alert in place and protect staff from unnecessary harm. We will continue implementation and rollout of changes to Care Plan documentation in Cerner. |